FINAL EVALUATION OF THE CARE POPULATION AND FAMILY PLANNING EXPANSION (PFPE) PROJECT

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by

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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ACKNOWLEDGMENTS

The team would like to express its sincere appreciation to the many individuals in many places who facilitated this evaluation by sharing their time, materials, and thoughtful comments and ideas in person and by telephone. We especially thank the community workers in Peru and Uganda, many of whom walked long distances to meet with us and share their experiences.

ABBREVIATIONS

AAAS	American Academy for the Advancement of Science
AIDS	acquired immunodeficiency syndrome
ANR	Agriculture and Natural Resources
AVSC	Association for Voluntary Surgical Contraception
CA	Cooperating Agency
CARE	Cooperative for Assistance and Relief Everywhere
CBD	community-based distribution
CDLMIS	Contraceptive Distribution and Logistics Management Information System
CEDPA	The Centre for Development and Population Activities
CREHP	Community Reproductive Health Project
CTO	Cognizant Technical Officer
CYP	couple year of protection
DHS	Demographic and Health Survey
DTC	Development Through Conservation
EPI	Expanded Program on Immunization
FPAU	Family Planning Association of Uganda
FPLM	Family Planning Logistics Management Project
FY	fiscal year
G/PHN/POP	The Office of Population, Center for Population, Health and Nutrition, Global Bureau of USAID
IEC	information, education and communication
INPPARES	Instituto Peruano de Paternidad Responsable
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JSI	John Snow, Inc.
LOP	length of project
MIS	management information system
MOH	Ministry of Health
MSH	Management Sciences for Health
MSPP	Multi-Sectoral Population Project
NGO	non-governmental organization
ODA	Overseas Development Administration (United Kingdom)
PACD	Project Assistance Completion Date
PFPE	Population and Family Planning Expansion Project
PHC	Primary Health Care
PIR	Project Implementation Report
PVO	private voluntary organization
RMG	Regional Management Group
RMU	Regional Management Unit
RTA	Regional Technical Advisor
SEAD	Small Economic Activity and Development
SOMARC	Social Marketing for Change Project
TAG	Technical Assistance Group
USAID	United States Agency for International Development

PROJECT IDENTIFICATION DATA

1.	**Project Title:**	CARE: Population and Family Planning Expansion Project
2.	**Project Number:**	DPE-3058-A-00-1011-00
3.	**Project Dates:**	
	Agreement Signed:	May 1,1991
	End Date:	April 30,1996
	PACD:	September 30, 1999
4.	**Project Funding:**	
	Authorized LOP:	$ 25,800,000
	Core Contract Value:	$ 22,300,000
	Add-on Value:	$ 3,500,000
	Matching Funds:	$ 7,100,000
	Obligations to 8/26/94:	$ 15,360,000
5.	**Mode of Implementation:**	Cooperative Agreement
6.	**Responsible USAID Officials:**	
	Cognizant Technical Officer:	Bonnie Pedersen
	Technical Advisor:	Nancy Stark

EXECUTIVE SUMMARY AND MAJOR ECOMMENDATIONS

Introduction

In the late 1980s, the Cooperative for Assistance and Relief Everywhere (CARE USA), the world's largest private, nonsectarian development and relief agency, conducted a comprehensive strategic planning exercise and found that rapid population growth was undermining the impact and accomplishments of CARE's development work. After examining its organizational capabilities and comparative advantages, CARE concluded that population and family planning activities should be added to its existing portfolio.

In 1990, CARE USA submitted an unsolicited proposal to the Office of Population of the United States Agency for International Development (USAID) requesting support for a Population and Family Planning Expansion (PFPE) Project that would allow CARE to develop an institutional capacity to design and implement family planning programs and to assist in the global expansion of high-quality family planning services.

Under the resulting five-year (May 1, 1991–April 30, 1996) Cooperative Agreement, CARE USA has successfully integrated population and family planning into its portfolio and has used PFPE resources to develop an impressive Population Program now active in more than 20 countries. Nearly triple the expected funds match has been raised. The participatory process used by CARE, as well as other aspects of CARE's experience, should be of interest to many organizations—other development organizations, other population Cooperating Agencies (CAs), other private voluntary organizations (PVOs), and USAID. Any follow-on project should have a balanced focus between expansion and quality improvement and should give special emphasis to reproductive health as a priority focus.

Findings

Institutionalization

Prior to the funding of The PFPE Project, the Board of Directors of CARE USA approved a population policy statement and a fledgling Population Unit was created within CARE's technical assistance structure. Later, CARE International also adopted a population policy statement.

The Population Unit is now fully functional with exceedingly competent, committed people and a good balance of geographical and technical expertise. A recent internal reorganization has reallocated tasks and responsibilities to take advantage of the team's varied geographical and technical expertise and to adjust to the changing demands on the Unit as CARE's Population Program expands and matures. Both at headquarters and in the field, the Population Unit enjoys high credibility and the Unit team has a reputation for quality and responsiveness. The strategy utilized by the Population Unit consists of five major components: support to the Country Offices, strategic planning, fund-raising, maintaining technical quality, and contributing to CARE and the wider professional community.

CARE's Population Program has been shaped by a conceptual framework consisting of five interrelated elements: policy, strategy, guidelines and tools, projects and services, and learning.

Underlying all aspects of the development of CARE USA's Population Program and the implementation of The PFPE Project has been the explicitly stated learning process approach of CARE's Program Division. This has meant looking outside CARE to the larger population and family planning community for information and lessons learned, as well as within CARE to other sectors. This has meant looking for programmatic weaknesses and mistakes as well as successes; CARE uses the term "embracing error to improve practice." Included in the learning process approach is a collaborative approach to monitoring and evaluation that attempts to include all relevant stakeholders and that constructively uses knowledge gained to improve performance.

In addition to a participatory midterm evaluation facilitated by eight of the PFPE-funded field projects, CARE has held a series of workshops and conferences to develop and advance the Population Program. The workshop/conference mechanism appears to have worked extremely well. The opportunity to collectively analyze and share issues has nurtured the development of what is now seen as a real population "community" inside CARE USA. It has also served as a useful vehicle for consolidating CARE's commitment to population and family planning.

No management issues were identified that at present detract from CARE USA's or the Population Unit's ability to execute The PFPE Project. On the contrary, the strong guidance from the central level and the independence of the field level appear to provide the right combination of direction and autonomy to allow for the optimal development of interventions. The learning process approach of "embracing error" has encouraged the CARE community to take risks, look outside of CARE for relevant expertise, bridge research with field work, and continually look to its experiences to learn more.

Considerable attention has been given to sensitizing and informing headquarters and field staff with regard to population issues and family planning programming. It is probable that further efforts will still be required especially with regard to field staff as additional countries add population programming to their portfolios, but essentially population and family planning is accepted and fully supported as a CARE programming sector at all levels and in all areas.

Recommendation: As the first major development agency to systematically introduce family planning into its total program, CARE USA's efforts to institutionalize population and family planning within CARE's programmatic portfolio should be recognized and applauded, and the participatory process by which institutionalization has been achieved is to be commended.

Field Project Implementation

The original PFPE Project design called for the implementation of 16 field projects predominantly in sub-Saharan Africa. However, just as the first four country field projects were being launched, the Office of Population moved to the Big Country Strategy. CARE USA agreed to also shift its focus and concentrate on fewer but larger projects in more demographically significant countries. As a result, CARE and the Office of Population agreed to reduce the number of field projects to 10. The CARE Country Offices in Latin America were especially receptive to this shift in focus.

In all, 10 CARE Country Offices have implemented PFPE-funded field projects. At present, eight are functioning: Bangladesh, Dominican Republic, Nepal, Niger, Peru, Philippines, Togo, and Uganda. The ninth, Kenya, is staffed and about to be launched. The tenth, Rwanda, was fully functional and is now suspended.

Careful, considerate deployment of the PFPE-funded technical resources has allowed a sizable number of other CARE Country Offices to also design and implement family planning activities. Bolivia, Cambodia, Ethiopia, Guatemala, Haiti, Honduras, Mali, India, Tanzania, West Bank-Gaza, and Zambia are implementing family planning projects with non-PFPE funds. Major non-PFPE-funded expansions in Peru and Uganda have also been planned. The Kenya project, while being launched with PFPE funds, will continue with non-PFPE funding. Still other countries are developing concept papers or undertaking other preliminary activities.

All field project design is guided by a set of explicit programming principles, adapted to population and family planning, which capture the essential lessons learned by CARE in its development programs over the years. CARE's project design capability has improved over time. The field projects are "integrated" into CARE's existing infrastructure in various ways which require further study. It is still difficult to draw conclusions about the quality of services provided, mostly because many field projects are just becoming fully operational. Training appears strong; IEC appears in need of attention. Logistics, an area where CARE has recognized expertise, also needs further attention. CARE is well aware that more attention needs to be given to monitoring and evaluation. More emphasis is needed on cost recovery. In the field, CARE enjoys strong and positive relations with counterpart institutions. CARE's field staff is competent and qualified.

Recommendation: Increased emphasis should be given to assuring the physical availability of contraceptive methods and avoiding outages in project catchment areas.

Recommendation: More emphasis needs to be given to increasing the availability of and improving the access to long-acting and permanent modern methods as well as to postpartum services.

Recommendation: Additional strength in evaluation, including operations research, would enhance CARE's ability to implement quality family planning projects and identify and replicate successful approaches.

Collaboration with other Population CAs

CARE USA has collaborated with and utilized the specialized skills of other population CAs from the very beginning. Drawing on the existing knowledge and lessons learned in the population field is an explicit component of CARE's learning process approach.

Examples of field collaboration are also numerous. However, some attempts at field collaboration have not been successful, generally because they were not sufficiently well planned and too much was left to chance. A common CARE project design is a network of community-based distribution (CBD) agents linked generally to public sector clinical facilities. Many other donors and population CAs focus on strengthening clinical services; it would be redundant for CARE to also focus here. Instead what is needed is close, explicit, planned collaboration—joint programming, if possible—to

create fully functioning family planning service delivery systems. Although for CARE, such planning and programming is almost totally a field function, many population CAs are more centrally focused; the Population Unit may need to actively facilitate the development of these types of linkages, especially in countries where the relevant CAs do not have a permanent in-country presence.

Recommendation: CARE USA should seek to systematically increase its programmatic field collaboration with other population CAs.

Project Funding

CARE USA's funding commitment to The PFPE Project was to match USAID's contribution US$0.40 to the dollar. To date, in terms of obligations, CARE has almost matched USAID dollar for dollar by raising US$21 million. To do this, CARE has attracted a diverse range of donors with the major portion of the funds obligated to date from CARE International members who secured funds from private, bilateral, and multilateral sources. Additional funds have come via CARE USA's Marketing Department. Lastly, CARE Country Offices have obligated US$1.9 million of their own funds. Only 28 percent of the match funds have been expended to date. CARE is being given a one-year no cost extension in order to spend down the match funds.

The identification and leveraging of funds specifically for population and family planning activities is considered an important function of the Population Unit in addition to its technical responsibilities. The Unit's expertise in this area has given it a certain degree of flexibility and has strengthened its ability to implement family planning programming in a timely manner. While recognizing how time consuming the raising of the match funds has been, the team felt the PFPE matching funds requirement had contributed greatly to the success of CARE's Population Program by increasing CARE's "ownership" of population as a new sector, by sharpening CARE's critical thinking when considering how to "market" population to its national and international donor community, and by creating a degree of programmatic flexibility that is not possible with a single donor. It does appear that CARE USA could effectively absorb and utilize additional funds if such funds were made available.

Recommendation: CARE USA should also be recognized for its success in raising the PFPE match funds and for its success in attracting a range of donors.

Recommendation: Any follow-on project should also require such a match at approximately the same percentage level but should not be tied to stringent expenditure schedules.

Recommendation: If a follow-on project is funded and increased funds are available, USAID should consider CARE USA to have an additional absorptive capacity for effectively deploying such funds.

Actual Versus Expected Project Outputs

CARE USA, with few exceptions, is well on the way to meeting or exceeding all the PFPE expected outputs. The major unachieved expected outputs are the couple years of protection (CYP) targets for the field projects other than Bangladesh. Many projects are just becoming fully operational and

their service delivery impact is just beginning to be demonstrated. The PFPE Project still has more than a year left.

Sharing Lessons Learned

To date, CARE USA's efforts to share its lessons learned have been directed primarily and appropriately to the CARE community. It would not be premature for CARE to begin documenting and sharing its rich experience and lessons learned with the larger community, especially the other major development organizations as well as the other population CAs and USAID. CARE's sharing of lessons learned should also extend to its partners—the counterpart governments, indigenous nongovernmental organizations (NGOs)/PVOs, and other local organizations with which it works—with particular attention paid to the potential for replicability and sustainability.

Recommendation: CARE USA should be encouraged to share its experiences and lessons learned with other development organizations, with other population CAs, USAID, and ultimately with its counterparts in the field.

Future Directions/Future Needs

Institutionalizing an entire new area of activity, especially a politically sensitive area like population and family planning, was a major undertaking for a decentralized, field-driven development organization like CARE USA. To enable each country to embrace population and family planning on its own terms required time, skill, and effort. Consequently, the major initial emphasis was necessarily on institutionalization and the creation of systems for designing and implementing family planning field projects. At this point, the emphasis is more on the actual implementation of field projects; it is realistic to expect that any follow-on project would continue this evolution of emphasis.

CARE USA's Population Program is already moving in a number of directions congruent with the evolving priorities of The Office of Population. There are CARE Country Offices in 13 of the 15 joint programming countries (all except Nigeria and Morocco) with family planning projects already implemented in more than half. CARE's number one comparative advantage will, of course, continue to be its infrastructure; CARE has tremendous presence in the communities with which it works.

As part of the long-range strategic planning process currently underway, each CARE Country Office will systematically consider whether there is a need for population and family planning programming in its portfolio. The expectation is that there will be considerable demand. In addition, CARE wants to expand current family planning programming within countries geographically and by continuing to focus on improving the quality of existing projects.

There is a very strong trend at CARE USA, underscored by the household livelihood security paradigm, toward increased cross-sector programming. In effect, CARE is looking for ways to deliver multiple messages synergistically, for ways to work and act more holistically, more ecologically. Whereas the population community is giving increased attention to gender equity and women's empowerment issues, it should be noted that gender and equity concerns were in part what led CARE to population and family planning. CARE USA's reproductive health involvement is

another example of the move toward working more holistically. Also, the reproductive health needs of refugee populations are of increasing concern to CARE USA. Although CARE traditionally has had a rural focus, peri-urban interventions are increasingly being considered, especially in countries where heavy internal migration has resulted in large population shifts and especially in secondary and tertiary peri-urban areas where no other population organizations are working.

Most of the field projects established to date are still basically fledglings. It is still too early to know which aspects are most successful and which least successful. The various forms and meanings of integration require further definition and exploration. Improving and refining the technical aspects and impact of the existing field projects will require as much attention as expansion; a continued focus on quality will be key.

The continued growth and improvement of CARE USA's Population Program will require additional technical expertise to provide adequate technical support to the field projects. Also, the demands of the field projects must be balanced with the demands of fund-raising. Ideally this expertise would be located both in Atlanta and within the Regional Technical Advisor (RTA) system.

Recommendation: Any follow-on project should have a balanced focus between expansion to new countries and quality of care improvements in existing projects.

Recommendation: Any follow-on project should give special emphasis to reproductive health as a priority focus.

Recommendation: Any follow-on project should specify a clearly defined system for assuring and providing adequate technical support to the field projects.

LIST OF RECOMMENDATIONS

1: As the first major development agency to systematically introduce family planning into its total program, CARE USA's efforts to institutionalize population and family planning within CARE's programmatic portfolio should be recognized and applauded and the participatory process by which institutionalization has been achieved is to be commended. (p. 14)

2: The Population Unit's ability to partially or wholly cover the RTA "cross-charge" should be continued and explicitly maintained in any follow-on project. (p. 16)

3: When DHS or other reliable data is available at the desired level of detail and is current, it should be used in lieu of a CARE-funded baseline or follow-up survey. (p. 17)

4: As planned, revisiting IEC should be a Population Unit priority, leading to the development of an overall IEC strategy. (p. 21)

5: While CARE USA is to be commended for its efforts to avoid duplication and to utilize existing resources, steps should be taken to assure that adequate provision has been made for all critical project elements during the design phase. (p. 21)

6: Increased emphasis should be given to assuring the physical availability of contraceptive methods and avoiding outages in project catchment areas. (p. 22)

7: More emphasis needs to be given to increasing the availability of and improving the access to long-acting and permanent modern methods as well as postpartum services. (p. 24)

8: Additional strength in evaluation, including operations research, would enhance CARE's ability to implement quality family planning projects and identify and replicate successful approaches. (p. 24)

9: While keeping in mind CARE's commitment to working with the poor and disenfranchised, higher priority should be given to designing and implementing cost recovery components in the field projects. The Population Unit should develop guidance in this area. (p. 25)

10: Project managers and field staff need to be made more aware of project costs and the use of cost data as a planning and management tool. (p. 25)

11: CARE USA should seek to systematically increase its programmatic field collaboration with other population CAs. (p. 26)

12: CARE USA should also be recognized for its success in raising the PFPE match funds and for its success in attracting a range of donors. (p. 29)

13: The issue of Country Office allocation of match funds should be addressed early on in any follow-on project. (p. 29)

14: Any follow-on project should also require such a match at approximately the same percentage level but should not be tied to stringent expenditure schedules. (p. 29)

15: If a follow-on project is funded and increased funds are available, USAID should consider that CARE USA has additional absorptive capacity for effectively deploying such funds. (p. 29)

16: CARE USA should be encouraged to share its experiences and lessons learned with other development organizations, other population CAs, USAID, and ultimately with its counterparts in the field. (p. 31)

17: Any follow-on project should have a balanced focus between expansion to new countries and quality of care improvements in existing projects. (p. 37)

18: Any follow-on project should give special emphasis to reproductive health as a priority focus. (p. 37)

19: Any follow-on project should include a mechanism for addressing the reproductive health needs of refugee populations. (p. 37)

20: Any follow-on project should specify a clearly defined system for assuring and providing adequate technical support to the field projects. (p. 37)

1. INTRODUCTION

1.1 Purpose of the Evaluation

In the late 1980s, the Cooperative for Assistance and Relief Everywhere (CARE USA), the world's largest private, nonsectarian development and relief agency, conducted a comprehensive strategic planning exercise in preparation for the 1990s. A major conclusion was that rapid population growth was undermining the impact and accomplishments of CARE's development work. After examining its organizational capabilities and comparative advantages, CARE concluded that population and family planning activities should be added to its existing portfolio. The Board of Directors of CARE USA subsequently approved a population policy statement and a fledgling Population Unit was created within CARE's technical assistance structure.

In 1990, CARE USA submitted an unsolicited proposal to the Office of Population of the United States Agency for International Development (USAID) requesting support for a Population and Family Planning Expansion (PFPE) Project that would allow CARE to develop an institutional capacity to design and implement family planning programs and assist in the global expansion of high-quality family planning services.

The Office of Population (G/PHN/POP) subsequently entered into a five-year (May 1, 1991–April 30, 1996) Cooperative Agreement with CARE to implement The PFPE Project. Because CARE was considered to have a well-developed system of monitoring and evaluation that was parallel to USAID's system and because CARE itself planned to conduct its own internal midterm evaluation, this single external evaluation was planned by USAID for year four to examine project performance and accomplishments to date and provide guidance for a possible follow-on project.

In the summer of 1994, CARE did, in fact, conduct comprehensive, collaborative midterm project evaluations of eight PFPE-funded field projects whereby a core evaluation team facilitated a process in which all relevant stakeholders participated to assess the strengths and weaknesses of each project and determine needed actions. The findings of these evaluations provided a solid foundation for CARE's November 1994 Lessons Learned Conference. Drawing on data from both of these events, this evaluation also included a broader examination of CARE's niche within the USAID strategy. The Scope of Work for the evaluation is set forth in Appendix A.

1.2 Evaluation Materials and Methodology

Extensive project and other related documentation was made available for review by the evaluation team. As part of a three-day team planning meeting in Washington, the team met with G/PHN/POP and other relevant USAID/Washington staff persons. The team then spent two days at CARE USA headquarters in Atlanta meeting with senior management and project staff. Additionally, in Washington and Atlanta, telephone interviews were held with USAID Mission staff, CARE International staff, and CARE field staff in a variety of roles and geographic locations. One-week site visits were then made to two pre-selected field projects in Peru and Uganda considered illustrative of CARE's family planning activities. Peru and Uganda were selected by USAID as the field projects to be visited because they were both USAID priority countries, they offered a variety of family planning service delivery models, they had been among the first to conduct and complete the

participatory midterm evaluation process, and they both will have large program expansions financed by non-USAID funds. Additionally, staff from Kenya traveled to Uganda to meet with the team. Appendix B contains the list of persons interviewed, and Appendix C contains the list of documents and materials reviewed by the team.

2. BACKGROUND

2.1 CARE USA and CARE International

Over a 50-year period, the meaning of the acronym CARE has evolved from the Cooperative for American Relief to Europe (CARE) to the Cooperative for Assistance and Relief Everywhere (CARE). Founded in 1945 to provide post-World War II food relief, CARE USA was joined in its efforts in 1946 by CARE Canada.

CARE USA's stated purpose is "to help the world's poor in their efforts to achieve social and economic well-being. We support processes that build competence and become self-sustaining over time. Our task is to reach new standards of excellence in offering disaster relief, technical assistance, training, food, other material resources and management in combinations appropriate to local needs and priorities. We also advocate public policies and programs that support these ends."

CARE USA is directed by a president and a 21-member Board of Directors and is headquartered in Atlanta, Georgia. About 180 staff are located in Atlanta; the overwhelming majority of CARE USA's staff are stationed in the field and are citizens of the countries in which they work. CARE USA currently has some 200 expatriate and close to 9,000 national staff. In 1994 CARE reportedly reached an estimated 27 million people with US$367 million in goods and services.

In the 1980s, seven of the countries that first received CARE's assistance founded their own independent CARE organizations: CARE Germany (1980); CARE Norway (1980); CARE France (1983); CARE Italy (1984); CARE Britain (1985); CARE Austria (1986); and CARE Japan (1987). These seven together with CARE Australia (1987), CARE Denmark (1988), CARE Canada and CARE USA make up the 11-member confederation that is CARE International.

CARE USA, CARE Canada, CARE Australia, and CARE Germany are the only CARE International members who have actual physical presence in countries other than their own; they are referred to as "lead" members. The other members play support and liaison roles, especially with regard to fund-raising. For example, CARE Britain has become a major family planning funding partner with CARE USA.

Only CARE USA has technical units centrally and a Regional Technical Advisor (RTA) system in the field. CARE USA's technical resources support all CARE countries, regardless of "lead" members. For example, CARE Canada is the "lead" member in Kenya, but the CARE Kenya programs receive more funding from CARE USA than from CARE Canada. CARE Australia generally emphasizes relief rather than development work. CARE Germany works almost exclusively in Eastern Europe.

CARE International is based in Brussels, Belgium. The 22-member Board of Directors (two representatives per member country) meets twice yearly. All CARE Country Offices use a unified accounting system with all financial transactions processed at a CARE financial center in the Philippines.

CARE USA has a long history of successful collaboration with USAID. Somewhat more than half of CARE USA's current funding comes from USAID. It also raises funds directly through mailings, gifts from major donors, corporations, and foundations. Funding is also received via other CARE International members who likewise receive funding from their national governments, the general public, corporations, and foundations as well as from entities like the European Union. CARE International itself helps raise funds directly from predominantly European nations without CARE affiliates. Lastly, funding is also received from various United Nations organizations.

All together, CARE International members currently work in 61 countries; CARE USA is the lead member in 36 countries.

2.2 CARE USA Programming

Until the 1970s, CARE USA was predominantly a relief organization with the distribution of food the major activity. Beginning in the late 1970s, CARE underwent a major paradigm shift which led to its becoming a major development organization. In looking at where CARE USA could best position itself in the future, three sectors were identified as CARE's initial focus beyond its traditional roles of emergency relief and rehabilitation:

- Agriculture and Natural Resources (ANR)
- Small Economic Activity and Development (SEAD)
- Primary Health Care (PHC)

CARE then proceeded to establish technical units to support each of these sectors. Interestingly, a major portion of this paradigm shift was leveraged by "seed" grants from USAID, first with regard to ANR and later with regard to SEAD. Thus, when population was later identified as a major issue to be addressed, a mechanism already existed to functionalize population via the creation of a technical unit, and a precedent existed for approaching USAID for "seed" money to help leverage this transition.

Currently, CARE USA is piloting a girls' education initiative with private money. Presently "housed" in the SEAD sector, the expectation is that girls' education will soon become a separate sector like population and family planning. The potential for synergistic linkages with population and family planning is already under discussion.

While CARE is often recognized for, and is proud of, its commitment to working in countries for long periods of time, the program portfolio within a specific country is not static. It changes over time as the country's needs change and, to some extent, as CARE itself evolves. CARE fosters sustainability by providing technical and managerial training that allow projects and communities to "graduate" from CARE's assistance. For example, CARE estimates that 70 percent of the water/sanitation systems initially financed by CARE have continued to operate under village committees. Likewise, numerous agricultural extension programs are now operating independently in many countries.

CARE has explicit criteria for entering and exiting countries and communities. The entrance criteria are need based. The exit criteria have to do with the increased ability of the local people to manage their own development. Several long-term CARE countries in Asia and Central America

are expected to "graduate" in the near future; it is considered likely that at least one will go on to form its own national CARE organization and be the first developing nation to become a member of CARE International.

Currently, CARE USA sees itself as being in a period of transformation with its future focus being more on partnerships and institutional capacity building than on the direct delivery of services. To this end, a policy dialogue is taking place within CARE USA and within CARE International. Even the traditional Country Office structure is being questioned.

CARE in the last decade has given major attention to strengthening its technical capacity and increasing its professionalism at all levels. In recent years, CARE USA has also been focusing on ways to improve its planning capabilities.

Currently CARE is developing, operationalizing, and institutionalizing an impact-based long-range strategic planning capability country by country that looks at long-term (up to 20 years) challenges and at CARE's specific niche in each country. About half of the CARE USA countries have worked through this long-range strategic planning process; the expectation is that all countries will have done so within a year.

This strategic planning process utilizes a newly developed, all-encompassing strategy or framework for conceptualizing and organizing CARE's programming referred to as "household livelihood security". "Household livelihood security" is comprised of the following elements: income, nutrition, women's status, family size, health, and natural resources.

CARE's intent is to apply the "household livelihood security" model across the whole relief-rehabilitation-development continuum in which CARE works. This approach is expected to allow an assessment of impact at the household level and facilitate cross-sectoral assessments that can focus more on synergies. A strategic planning methodology based on a "Human Development Index" is being developed. Over time, CARE expects to be working in approximately the same number of countries, as high index "graduates" are replaced by lower index countries.

2.3 Emergence of Population as a CARE Sector

By the late 1980s there was a growing recognition within parts of CARE USA centrally and in the field that rapid population growth was undermining the accomplishments and impact of CARE's development work. A strategic planning exercise undertaken at that time (often referred to as the 1990 Tarrytown Conference) supported this growing consensus. CARE USA examined its organizational capabilities and comparative advantages and concluded that population and family planning programming should be integrated into CARE's existing portfolio.

The Board of Directors of CARE USA adopted the following population policy statement:

> CARE believes that poverty and rapid population growth are synergistically related. The combined effect of these two forces impedes the achievement of economic and social well being.
>
> According to the United Nations Fund for Population Activities there are five factors which determine fertility and hence affect population growth. They are: women's

status, maternal and child health, information about and access to family planning, family income and female education. Given that CARE is a development agency, and given that men's and women's decisions about family planning are best made in a context which is favorable to development, CARE seeks to support activities in all sectors, which will positively affect the five fertility factors mentioned above.

CARE is active in the area of reproductive health education and service, both through its own programs and in cooperation with other entities in the host countries where it operates. CARE upholds the rights of nations and their people to identify their own problems and formulate responses to them, while recognizing the right of every man and woman to unrestricted access to all methods and means of family planning information and services. CARE's support and services are and will continue to be governed by local laws, customs, religious beliefs, international health standards and, most importantly, by the voluntary choice of individuals.

Early on, the decision was made to operationally establish population and family planning as a separate sector rather than put it within an existing sector like PHC. This was done to underscore its importance as a major organizational priority, to make it more visible both internally, and externally, in effect, to "really own it."

Soon after the Population Unit was established, an unsolicited proposal was submitted to USAID's Office of Population requesting support for The PFPE Project.

2.4 CARE USA's Comparative Advantages

CARE USA believes that "by clustering population projects with other CARE programs and building on the infrastructure developed over fifty years, behavioral and institutional changes could be realized on a global scale." Specifically, when requesting support for The PFPE Project, CARE saw itself as offering strong comparative advantages that would augment and complement those of the other Cooperating Agencies (CAs) then working with the Office of Population:

- CARE's efforts were of significant scope; CARE USA then had some 250 international and 7,000 national staff working in 38 countries. Its FY90 budget was US$375 million, including cash, food, and other materials.

- CARE's funding sources were multiple; both directly and through other CARE International members, additional funding was received from private and non-U.S. government sources as well as from international organizations such as the European Union, the World Bank, and the United Nations.

- CARE's commitment to working in countries over long periods of time fostered a strong relationship with the host government, high credibility, an in-depth knowledge of local conditions, and the development of a stable, highly competent national staff.

- CARE's logistics capabilities allowed it to distribute commodities, provide training, and deliver services to isolated areas and dispersed populations in a highly cost-effective manner and with excellent accountability.

- CARE's field operations were strong with hands-on management down to the village level; CARE was known for getting things done and for having solid administrative, financial, and reporting systems.

- CARE had a strong Africa presence with country offices and ongoing projects in 18 African countries.

- CARE emphasized local participation; working with a wide array of local organizations from project design through implementation and evaluation increased the probability that projects would be appropriate and feasible with significant local buy-in of effort and resources. This approach also increased the potential for success and sustainability.

- CARE's sectoral technical assistance capacity was well-established; headquarters and regionally based technical advisors in primary health care, small economic activity development, agriculture and natural resources, and training already provided in-house, ongoing, quality technical assistance.

- CARE emphasized qualitative and quantitative evaluation of all its development projects, focusing not only on outputs but also on long-term sustainability of benefits.

- CARE had an established track record of identifying, documenting, and disseminating lessons learned among its own projects as well as to other organizations via the regional technical advisor system, evaluations, cross-visits, training events, publications, and networking.

- CARE's work was cost effective; its indirect cost rate was a very modest eight percent, and it also had the ability to leverage substantial donor funds.

3. PFPE PROJECT DESIGN

3.1 Goals, Purposes, and Objectives

As stated in the original proposal, the goal of CARE's PFPE Project was

- "to enhance the freedom of individuals in developing countries, especially sub-Saharan Africa, to choose the number and spacing of their children and
- to encourage a population growth rate consistent with each country's goals for economic and social development."

The stated purpose of The PFPE Project was

- "to expand the use and availability of voluntary family planning services and to improve the quality of services delivered."

The three main objectives were

- "developing CARE's institutional capacity to design and implement family planning programs;
- testing new models of family planning service delivery which draw upon CARE's existing work in other sectors; and
- increasing access to family planning information, services and supplies for developing world couples, especially in rural and other hard-to-access areas."

3.2 Expected Project Outputs

Both institutional and field project outputs were specified in the Cooperative Agreement. The institutional level outputs expected were those changes within CARE that would foster the development of a technical and institutional capability in population and family planning. This capability would allow CARE to implement additional projects using its own funds and attract substantial new resources from donors other than USAID. The institutional level outputs were the following:

- Population Unit created with overseas regional technical team
- Staff members from 15-20 overseas offices trained
- Increase in number of staff with population and family planning experience
- All CARE Country Offices (38) address population in their Multi-Year Plans
- US$7.1 million raised from major non-USAID donors
- Minimum of one ANR, one SEAD, and four PHC major subprojects integrating family planning activities
- Collaborative relations established with a minimum of 10 population/family planning agencies
- Population strategy statement developed and institutionalized
- Evaluation protocol designed and institutionalized

At the field project level, the outputs expected were the following:

- 16 family planning service delivery subprojects designed
- Commodities distributed
- All projects evaluated
- Minimum of eight family planning service delivery models tested
- 2,232,100 couple years of protection (CYPs) provided (if Bangladesh included); 809,400 CYPs provided (if Bangladesh not included)
- 2,232,100 women of reproductive age reached (if Bangladesh included); 1,092,100 women reached (if Bangladesh not included)

3.3 Project Strategy

In accordance with its goals, objectives, and expected outputs, The PFPE Project was designed with both an institutional development strategy and a field project strategy.

Institutionally, CARE USA intended to develop its own capacity to design, implement, and evaluate family planning service delivery projects in order to successfully carry out family planning projects in the field. CARE also saw itself becoming a recognized, active participant in the population arena able to learn from and share with other organizations. Thus, CARE intended to increase its technical support for family planning by further developing the headquarters-based Population Unit, fielding a team of Regional Technical Advisors for population and family planning, collaborating and contracting with other family planning organizations, and hiring new staff persons with family planning expertise as well as training existing staff.

The field strategy foresaw providing funding for new family planning country projects and the addition of family planning components to already existing CARE projects. This start-up funding would allow CARE to develop a field level track record which, along with the newly developed in-house technical capability, would then be the basis for leveraging additional funding from other, non-USAID donor sources.

3.4 Project Funding

The total cost of The PFPE Project was estimated at US$32.9 million. Of this, US$25.8 million was to be USAID's contribution, originally expected to be composed of US$17.8 million in core funding and US$8 million in buy-in funding. CARE USA was to provide a 40 percent match of USAID's core funding, i.e., up to US$7.1 million to match the expected US$17.8 million in core funding.

4. FINDINGS

4.1 Institutionalization

CARE USA's day-to-day program operations are directed by an executive vice-president, a senior vice-president, and five Directorates. All of the technical sectors, including the Population Unit, are grouped under one Directorate, the Technical Assistance Group (TAG), along with the other sector units (PHC, SEAD, ANR, Food Security). The CARE Country Offices are grouped under another Directorate, the Regional Management Group (RMG), into five Regional Management Units (RMU). Operationally, the sector units provide technical support to the five Regional Management Units which have direct line authority to their respective country directors. The country directors have direct line authority to the project managers of all the projects in their country's portfolio. Therefore, at the country level, principal responsibility for the implementation of population and family planning activities rests with the country director.

Thus, officially, the Population Unit relates to PFPE Project activities in the field via the RMG and RMUs and the country directors. In practice, there is also considerable direct contact between the Population Unit and the country population and family planning project managers.

The original PFPE Project design called for the implementation of 16 field projects predominantly in sub-Saharan Africa. However, just as the first four country field projects were being launched as planned (in Niger, Rwanda, Togo, and Uganda), the Office of Population changed focus somewhat and adopted its Big Country Strategy. To accommodate this new strategy, CARE USA agreed to also shift its focus and concentrate on fewer but larger projects in more demographically significant countries. As a result, the Office of Population and CARE agreed to reduce the expected number of PFPE-funded field projects to 10.

CARE USA has used the resources of The PFPE Project to build an entire Population Program around the Project. In this regard, The PFPE Project has been indispensable. From the beginning, many CARE Country Offices not scheduled to be part of The PFPE Project indicated a strong interest in incorporating family planning activities into their country portfolios. The technical expertise and resources of the Population Unit and its RTAs initially supported both project design activities and the leveraging of funds from other sources. Regardless of funding source, all Country Offices and all family planning field projects can access the RTAs and the technical support and resources of the Population Unit and all participate fully and equally in all aspects of CARE's Population Program.

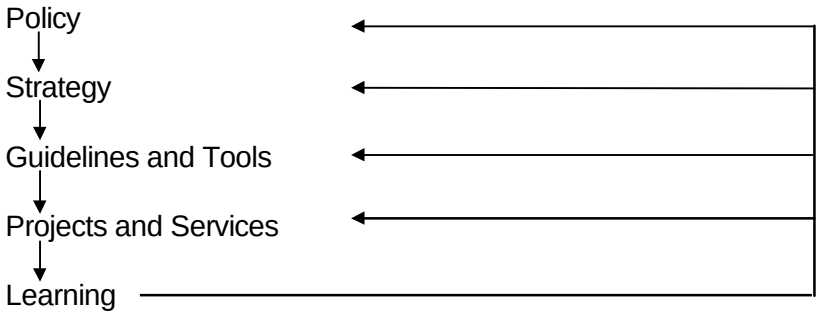
When The PFPE Project was first initiated, the CARE USA headquarters were in New York City. The original Population Unit team of six included three senior technical staff: a director, a deputy director, and a senior population advisor. During this period, for multiple reasons, CARE USA was considering relocating its headquarters. In early 1993, CARE headquarters moved to Atlanta. Of the six Population Unit staff based in New York, only one, the senior population advisor, ultimately made the move to Atlanta, assuming the role of director at that time.

Rebuilding the Population Unit staff has taken time and energy and has only recently been completed. Initially, reflecting the original PFPE focus on Africa, the Population Unit staff had very strong Africa backgrounds in addition to strong technical backgrounds in family planning. The

recent addition of a senior population advisor with a strong Latin American background nicely complements the Unit's African-oriented expertise as well as adding needed technical strength. Presently, the Population Unit is fully functional with exceedingly competent, committed people and a good balance of geographical and technical expertise. A recent internal reorganization has reallocated tasks and responsibilities to take advantage of the team's varied geographical and technical expertise and adjust to the changing demands on the Unit as CARE's Population Program expands and matures.

Both at headquarters and in the field, the Population Unit enjoys high credibility and the Unit team has a reputation for quality and responsiveness. Within CARE USA, the development of the population and family planning sector is viewed as a model to be emulated when operationalizing girls' education as a sector.

CARE's Population Program has been shaped by a conceptual framework consisting of five interrelated elements that relate in feedback as follows:



To address the last element first, underlying all aspects of the development of CARE USA's Population Program and the implementation of The PFPE Project has been the explicitly stated learning process approach of CARE's Program Division. This has meant looking outside CARE to the larger population and family planning community for information and lessons learned, as well as within CARE to other sectors. This has meant looking for programmatic weaknesses and mistakes as well as successes. CARE uses the term "embracing error to improve practice." Included in the learning process approach is a collaborative approach to monitoring and evaluation that attempts to include all relevant stakeholders and constructively uses knowledge gained to improve performance.

The positive policy environment created by the population policy statement adopted by CARE USA and the positioning of population as a separate sector within CARE provided a solid foundation on which to build. This foundation was greatly enhanced in November 1992 when the Board of Directors of CARE International considered a range of possible options with regard to population and endorsed the most activist position: cluster efforts to enhance the status of women and improve access to high-quality family planning services. This was the first time CARE International had adopted a programmatic statement; the statement also acknowledged the programming and financial implications of this decision. The Population Unit was instrumental in developing the population policy paper presented for the Board's consideration.

The strategy utilized by the Population Unit consists of five major components: support to the Country Offices, strategic planning, fund-raising, maintaining technical quality, and contributing to CARE and the wider professional community.

The provision of technical support to the Country Offices in the design, implementation, and evaluation of their family planning projects is seen as the Unit's most key responsibility. The Unit's Annual Operating Plan outlines a specific program of support to each individual Country Office having or developing a family planning project. The Unit's strategic planning management strategy is aimed at helping to develop appropriate short- and intermediate-range objectives within realistic time frames and then monitoring progress toward their achievement. The Unit's fund-raising strategy aims to secure a large, diversified funding base for CARE's Population Program.

To establish and maintain technical quality, the Population Unit has developed and disseminated an entire series of guidelines to support project managers and technical staff and guide the implementation of CARE's Population Program. Topics covered include the following:

- Design guidelines for population project proposals
- "How-to" guidelines for setting quantitative intermediate behavioral goals
- Budget, procurement, and travel guidelines
- Developing successful information, education, and communication (IEC) programs: guidelines for program managers
- Training guidelines
- Quality of care supervision tool
- Service statistics
- Monitoring and evaluation guidelines
- Assessing management capacity among nongovernmental organizations (NGOs)
- Project Implementation Report (PIR) format
- Portfolio analysis questionnaire
- Population sector guidance for strategic plan

Further modules on counseling and financial sustainability are to be developed. All of the guidelines are considered works in progress that will be expanded and modified over time. Attention is also given to staff development and providing project managers with pertinent articles and other information to help them stay up to date in their field.

The team reviewed the guidelines collection and found the materials comprehensive, up-to-date, and generally of good quality. CARE has done a good job compiling and utilizing materials already available. In addition, several of these—the quality of care supervision tool and the management assessment tool—are original contributions by the Population Unit to The PFPE Project and CARE and merit consideration by a wider audience. The Managing Capacity Assessment Tool to assess the managerial and functional capability of organizations being considered for partnership could be a significant contribution to both development agencies and population CAs trying to identify local counterparts in the field.

Specific issues have also been addressed through a series of participatory workshops involving outside experts (often from other population CAs), the family planning field project managers, and the Unit team, beginning with a workshop to strategize the design and implementation of The PFPE Project. The June 1992 Mombasa workshop focused on quality of care, service statistics, and project reporting using a very participatory, creative case study approach. The November 1993 Playa Hermosa strategic planning meeting was organized around the theme "Moving Toward Impact" and focused on project progress to date and learning strategies.

In the summer and fall of 1994, the eight PFPE-funded field projects each organized an intensive, participatory midterm evaluation that scrutinized each project's progress to date and led to the identification of needed actions. The November 1994 Atlanta conference/workshop on "Lessons Learned" built on these participatory midterm evaluations. The logical next step, a "dissemination" workshop to begin formally sharing lessons learned with organizations outside the CARE community, is being planned for February 1996.

The workshop/conference mechanism appears to have worked extremely well. The opportunity to collectively analyze and share issues concerning The PFPE Project and field project implementation has nurtured the development of what is now seen as a real population "community" inside CARE USA. It has also served as a useful vehicle for consolidating CARE's commitment to population and family planning.

No management issues were identified that at present detract from CARE USA's or the Population Unit's ability to execute The PFPE Project. On the contrary, the strong guidance from the central level and the independence of the field level appear to provide the right combination of direction and autonomy to allow for the optimal development of interventions. The learning process approach of "embracing error" has encouraged the CARE community to take risks, look outside of CARE for relevant expertise, bridge research with field work, and continually look to its experiences to learn more.

In short, the process of weaving population and family planning into CARE's basic fabric has, for the most part, been completed.

The "household livelihood security" concept captures the essence of CARE's work and the organization's focus on facilitating the access of the disadvantaged to a combination of resources to guarantee family sustainability. Family size is a key element. When the recently developed impact-based long-range strategic planning process is complete, every country will have systematically considered population as a part of its country portfolio.

Considerable attention has been given to sensitizing and informing headquarters and field staff with regard to population issues and family planning programming. It is probable that further efforts will still be required, especially with regard to field staff, as additional countries add population programming to their portfolios, but essentially population and family planning is accepted and fully supported as a CARE programming sector at all levels and in all areas.

Recommendation 1: **As the first major development agency to systematically introduce family planning into its total program, CARE USA's efforts to institutionalize population and family planning within CARE's programmatic portfolio should be recognized and applauded and the <u>participatory process</u> by which institutionalization has been achieved is to be commended.**

4.2 Field Project Implementation

As described previously, the original PFPE Project design called for the implementation of 16 field projects predominantly in sub-Saharan Africa. However, just as the first four country field projects were being launched as planned (in Niger, Rwanda, Togo, and Uganda), the Office of Population moved to the Big Country Strategy. To accommodate this new strategy, CARE USA agreed to also shift its focus and concentrate on fewer but larger projects in more demographically significant countries. As a result, CARE and the Office of Population agreed to reduce the number of field projects to 10.

The CARE Country Offices in Latin America were especially receptive to this shift in focus. Consequently, the next four country projects were implemented in Bangladesh as planned and in the Dominican Republic, Peru, and the Philippines.

In all, 10 CARE Country Offices have implemented PFPE-funded field projects. At present, eight are functioning: Bangladesh, the Dominican Republic, Nepal, Niger, Peru, the Philippines, Togo, and Uganda. The ninth, Kenya, is staffed and about to be launched. The tenth, Rwanda, was fully functional and is now suspended.

Careful, considerate deployment of the PFPE-funded technical resources has allowed a sizable number of other CARE Country Offices to also design and implement family planning activities. Bolivia, Cambodia, Ethiopia, Guatemala, Haiti, Honduras, Mali, India, Tanzania, West Bank-Gaza, and Zambia are implementing family planning projects with non-PFPE funds. Major non-PFPE-funded expansions in Peru and Uganda have also been planned. The Kenya project, while being launched with PFPE funds, will continue with non-PFPE funding. Still other countries are developing concept papers or undertaking other preliminary activities.

4.2.1 Regional Technical Advisors

The Regional Technical Advisors function like in-house consultants; their services are generally requested by the Country Offices and paid for out of country project budgets. The RTAs have set daily rates (a stiff US$400 per day) which are "cross-charged" from the country project budgets back to the respective unit budgets.

Each RTA visit has an agreed-upon work scope and the work performed is evaluated by the Country Office after each visit. The country directors and/or project managers wishing technical assistance are not obligated to use the RTAs. In fact, they are encouraged to use local technical expertise when available. This option of using an RTA or going elsewhere for technical assistance puts a certain pressure on the RTAs as they are likely to be the most expensive choice. However, in addition to their technical knowledge, the RTAs are often viewed as having "added value," such as their detailed knowledge of CARE institutionally, a consistent approach that dovetails with Population Unit guidance, a regional and sometimes global respective including lessons learned from other field projects, and a liaison relationship with potential donors.

The PFPE Project began with two Regional Technical Advisors in Africa. Within 18 months, one of the African RTAs left CARE and was not immediately replaced, given the Project's shift in country emphasis. Instead, an RTA for Asia was hired. Within the past year, an RTA for Latin American

was added. At present, the RTA for East Africa is 50 percent population/50 percent AIDS while the RTA for West Africa position is vacant.

As a deliberate strategy, the Population Unit has used PFPE Project resources to cover an RTA's "cross-charge" in order to facilitate a Country Office's access to this valuable resource. This has been especially useful when a Country Office wants to design a family planning program but has no funds budgeted for "hiring" the RTA. When appropriate, the Population Unit may also suggest to a Country Office that the RTA could help with a design or implementation function. This approach has contributed to the rapid responsiveness and problem-solving flexibility for which the Unit and population RTAs are known.

Recommendation 2: **The Population Unit's ability to partially or wholly cover the RTA "cross-charge" should be continued and explicitly maintained in any follow-on project.**

4.2.2 Project Design

All programming within CARE USA's Program Division is guided by a set of explicit programming principles that capture the essential lessons learned by CARE in its development programs over the years:

- Address significant problems. Projects should address widely shared concerns and needs and permit replication to wider audiences.
- Work with poor people. Projects should address the needs of the poor and disenfranchised, seeking those who are physically or socially the hardest to reach.
- Participation. The affected communities must be meaningfully involved in defining the problems to be addressed and the design, implementation, and evaluation of projects.
- Adaptability. Projects should be adapted to local needs, resources, and constraints.
- Sustainability. Projects must build the institutional and financial capacity of the participating population to maintain the development process after CARE departs.
- Fundamental change. Projects must improve the material conditions and promote the attitudinal changes that will allow poor people in developing countries to take control over their own lives.

These principles, adapted to population and family planning, form the context in which field projects are designed. Framed in country-specific terms, each project design seeks to answer the following questions:

- What are the critical barriers to access to high-quality family planning services?
- What is CARE's infrastructure and comparative advantage relative to other population assistance agencies?
- Where do CARE's strengths and family planning needs overlap?

The various elements of family planning service delivery—partners, quality of care, service delivery strategy, staff skills, IEC, management development, contraceptive logistics, monitoring and evaluation, financing—are then examined individually to determine CARE's niche.

CARE is by and large a programmatically decentralized organization with project design generally a field up function. However, since population as a new sector developed essentially at headquarters and moved to the field, the Population Unit was heavily involved in project design initially. Many of the original field project proposals were, in fact, written by Unit staff.

As CARE USA's Population Program has grown and field expertise has grown, this is no longer the case. The consensus at headquarters and in the field is that CARE's population project design capability has both expanded and improved over the course of The PFPE Project. Although all field project proposals are reviewed by the Unit team for technical soundness, project design is now essentially a field function. This increase in field project design capability should result in more realistic, achievable project designs that are more smoothly implemented.

For the past decade, it has been a CARE USA prerequisite that all CARE field projects begin with a baseline assessment against which impact is measured. Thus, all of the population and family planning field projects, regardless of funding source, have begun with a standard baseline survey based on the Demographic and Health Survey (DHS) format, generally carried out by a local university or research institution. Often supplemental surveys are also conducted to assess the availability of clinical services or the strengths of the local NGO/private voluntary organization (PVO) community. Similar follow-up surveys are to be conducted at the end of each project.

Because of the time involved in making the field projects truly operational, some project mangers expressed concern that follow-up surveys will be done prematurely and will not show the real impact of their projects.

The baseline surveys undertaken appear to be comprehensive and well executed. Additionally, they confirm that the CARE field projects are indeed targeting areas with very low contraceptive prevalence rates relative to the national average and/or are reaching those with the least access to services. It did appear that some of the baseline surveys perhaps duplicated work done fairly recently by national DHS surveys.

Recommendation 3: **When DHS or other reliable data is available at the desired level of detail and is current, it should be used in lieu of a CARE-funded baseline or follow-up survey.**

4.2.3 Integration and Service Delivery Models

The PFPE Cooperative Agreement calls for the "testing" of eight new service delivery "models" based on the manner in which the field projects are "integrated" into CARE's existing structure. This integration has taken different forms and different meanings in different field projects. At present five "models" are described in theory but in practice a specific field project may contain more than one model.

The "models" and the PFPE-funded field projects reportedly demonstrating them are the following:

- Targeting CARE focus regions (Peru ,Uganda)
- Adding family planning to existing CARE projects (Bangladesh, the Dominican Republic, Niger, Peru)

- Borrowing approaches from other sectors (Bangladesh, Togo)
- Capitalizing on CARE's logistics network (the Philippines)
- Supporting local NGOs (Bangladesh, the Dominican Republic, Niger, Peru, the Philippines, Uganda)

Almost all of CARE's family planning field projects are clustered with at least one other project from another sector, i.e., they operate in the same geographic catchment area. At the time of the midterm evaluation, of the 15 active family planning field projects, both PFPE-funded and non-PFPE-funded, nine were clustered with PHC projects, seven were clustered with ANR projects, five with SEAD projects, and four with Food.

However, the relationship between the projects varies from country to country. Often, as was seen in Uganda, the integration is what might be called parallel with the two projects operating side by side. Coordination and some sharing of resources exists within the CARE Country Office structure, but, operationally, the projects function separately in the field. CARE Uganda's family planning project, the Community Reproductive Health Project (CREHP), has been started in three densely populated but essentially rural districts in southwestern Uganda where a CARE Development Through Conservation (DTC) Project was already operational. In fact, it was through the DTC Project activities that CARE Uganda became aware that population and family planning was a community priority in the DTC area even before CARE USA decided to add population and family planning as a sector. The original project design envisioned utilizing DTC extensionists to also carry out family planning activities. For reasons specific to this area of Uganda, this was not done, and CARE Uganda chose to recruit additional community based distribution (CBD) agents in the DTC communities and initially target this existing CARE focus region with a parallel integration model. However, CREHP and DTC are currently engaged in a joint planning process for the future in which they are explicitly looking for synergies so yet another integration model will likely emerge.

A second form of integration is what might be called an aggregated model, as was seen in Peru in both peri-urban Chimbote and rural Cajamarca, where family planning activities have been added to existing CARE programs in other sectors through CARE Peru's Multi-Sectoral Population Project (MSPP). The MSPP Project works through eight other CARE projects in all four of CARE Peru's other programmatic sectors: PHC, SEAD, ANR, and Food Security. The committees of women running the community kitchens of CARE's PRODIA project and the women's groups receiving entrepreneurial training and small loans through CARE's MUJER project as well as extension agents working in water and sanitation have identified group members to be trained as family planning promoters. These promoters provide family planning information and supplies to their groups as well as to others. They also make referrals to public sector family planning clinics. As in Peru and Uganda, all the PFPE-funded field projects with the exception of the Philippines contain a large community-based volunteer or CBD component. In all but Bangladesh this CBD component is linked with the strengthening of clinical sites to which referrals are made.

Because family planning is the newest sector, clustering has generally meant adding family planning to catchment areas already served by projects in other sectors. However, in both Peru (the peri-urban areas of Iquitos) and eastern Uganda, expansions are underway that extend to areas not previously served by any CARE sector. As other sectors are clustered with population and family planning, still more integration models will result.

In several instances, family planning field projects have been implemented by using service delivery approaches already shown to be effective by other sectors. The village outreach approach used in Bangladesh to expand immunization coverage is also being used to expand access to family planning methods. Likewise in Togo, a successful ANR "innovative villager" model was used to develop a cadre of male family planning CBD workers.

In the Philippines, a quite different project has been implemented which capitalizes on CARE's recognized expertise in logistics. Historically, CARE Philippines' portfolio has focused largely on the distribution of food commodities. When the need for a national contraceptive distribution system emerged, the government and USAID requested CARE's support to implement a distribution system based on a pilot model designed by the Family Planning Logistics Management (FPLM) Project of John Snow, Inc. (JSI). In less than three years, the Contraceptive Distribution and Logistics Management Information System (CDLMIS) has covered most of the country and is currently distributing contraceptives valued annually at approximately US$12 million. The success of the project has moved the government to pilot the integration of the Expanded Program on Immunization (EPI) program into the distribution system and make substantial efforts to financially institutionalize it.

Not surprisingly, almost all of the field projects fit the model of supporting local NGOs, a historical strength of CARE's development approach.

4.2.4 Midterm Evaluations and Lessons Learned Conference

As mentioned previously, the eight active PFPE-funded field projects were each involved in a collaborative, participatory evaluation process involving all relevant stakeholders during the summer and fall of 1994. The Population Unit provided clear, comprehensive guidance and considerable technical assistance to facilitate this process.

The evaluation, while looking at actual versus planned achievements, was designed to emphasize process over outcome and lessons learned and future plans. Although also designed to use existing data and reports, the participatory evaluations clearly were time and labor intensive. Many CARE collaborators encountered during the field visits had taken part in the evaluation or were knowledgeable about the process. In spite of the time and labor demands, most CARE staff members and other stakeholders spoke extremely positively of the process as a real learning opportunity that strengthened ownership of and commitment to the field projects. It was not always obvious that a clear action plan had resulted from the process.

The process and results of the midterm evaluations formed a major portion of the November 1994 Lessons Learned Conference in Atlanta in which all family planning project managers participated. Collectively, the various project elements were ranked from best to worst as follows: contraceptive supply, counterpart relations, quality of care, clinical services, inter-sector programming, training, community-based distribution, financing, IEC, monitoring and evaluation, and management development. All in all, the team found CARE's midterm evaluation process and the use of the results as the foundation for the Lessons Learned Conference to be exemplary and innovative.

4.2.5 Quality of Care

From the beginning, the Population Unit has focused on assuring high-quality care in its population and family planning field projects using as quality guides the six elements of the Bruce framework: choice of methods, technical competence, information and counseling clients, interpersonal relations, mechanisms to encourage continuity, and appropriate constellation of services. A quality of care supervision tool was developed early in The PFPE project; about half of the field projects report using it in the field in some form. Data on findings have not yet been collected and analyzed. During the field visits, it was clear to the team that both CARE field staff and counterparts view quality of care as a priority focus. At this point, however, it is still difficult to draw conclusions about the quality of services provided, mostly because many field projects are just becoming fully operational.

4.2.6 Training

As previously noted, numerous training events have been given in the field for CARE staff from other sectors to introduce population and family planning. In Peru, for example, a one-day workshop was held in the MSPP project's first year for all CARE staff; the intent is to repeat this workshop within the year because of staff transfers and turnover.

As would be expected, training has been a major component of most field projects. In some, the amount of training required has been greater than initially planned; it has also been necessary in some cases to create a training capacity. In many projects, there has been training of health sector clinical staff as well as training of CBD workers. Generally the health sector clinical training has been done first so that referral sites would be operational once the CBD workers were trained and functioning.

The team observed two training interventions while in Peru. The first (in Chimbote) was for Ministry of Health (MOH) clinical family planning providers (about 50 nurses, midwives, and physicians) and was a straightforward, didactic contraceptive update on hormonal methods. The principal trainers were a physician from the population studies institute at Peru's most prestigious university and the MSPP deputy director, also a physician. The second training (in Cajamarca) was for recently recruited CBD workers, both men and women. This four-day workshop was being co-facilitated by CARE staff and MOH trainers. The materials and participatory methodology observed appeared to be excellent; the participants were enthusiastic and excited about what they were learning.

In Uganda, no training was observed but a number of trainers were interviewed. The CREHP project had assumed initially that the INTRAH-trained MOH master training team would provide the needed CBD training. However, the master training team kept postponing scheduled training sessions and was only able to complete one training course in a one-year period. Therefore, CREHP decided to develop a local training capability and engaged the MOH master team to provide a two-week training of trainers course instead. There is now a 13-person district training team, 12 from the MOH and one from the Family Planning Association of Uganda (FPAU), the Ugandan International Planned Parenthood Federation (IPPF) affiliate. These trainers were chosen from the MOH staff previously trained by the project; they are a mix of nurses, midwives, and medical assistants, most of whom work in the clinics and health posts to which the CBD workers make referrals.

4.2.7 IEC

This area was identified as problematic by the Population Unit, the RTAs, and a number of the field projects during the midterm evaluations. When the various project elements were ranked, to the surprise of many, IEC was near the bottom.

Often the expectation in the original project design was that suitable print IEC materials in sufficient quantities would be available from other sources. This almost invariably turned out not to be the case. Either the materials were never produced as planned or the materials were made available only if CARE would pay to have them reprinted. The field projects had not anticipated this and therefore did not have funds budgeted for this purpose. In other instances, the materials available were more oriented toward a high literacy or very urban audience or were not available in the local languages.

The Population Unit is already very aware of these difficulties and in response is planning a comprehensive review of current approaches and materials to identify what can be used and what can be adapted. The intent is to provide increased technical assistance to the field to expand their concept of IEC and help them budget more appropriately. A regional IEC workshop for Asia is also being planned.

CARE generally is recognized throughout its sectors for its skill at doing community level IEC. The Population Program's approach to IEC appears to focus mainly on printed materials and interpersonal communications. The IEC module in the Guidelines Collection is simple, useful, and attractively presented but perhaps limited.

In general, the team found this focus appropriate. Although several field staff members indicated that CARE does not "do" mass media, the team also felt more consideration should be given to opportunities to directly or indirectly utilize mass media modalities.

Recommendation 4: **As planned, revisiting IEC should be a Population Unit priority, leading to the development of an overall IEC strategy.**

Recommendation 5: **While CARE USA is to be commended for its efforts to avoid duplication and to utilize existing resources, steps should be taken to assure that adequate provision has been made for all critical project elements during the design phase.**

4.2.8 Logistics

The Philippines CDLMIS appears to be a very successful project. It is noteworthy that the Philippines' Secretary of Health explicitly praised this project during the recent United Nations International Conference on Population and Development in Cairo. However, although ranked as a very successful project element after the midterm evaluations, contraceptive logistics appears to remain a problem in many countries. The MOH clinics and health posts in both Peru and Uganda have had serious stock outages in the past year that have undermined the effectiveness of CARE's field projects there. Probably nothing sabotages the success of a family planning program faster

than frequent contraceptive shortages. It is understandable why, especially in countries where the CARE family planning field projects work with the public sector health system, CARE might be reluctant to create systems that bypass the public sector systems however dysfunctional they may be. Nonetheless, given CARE's recognized expertise in the field of logistics, it would seem that assuring contraceptive supplies would be an ideal problem area for CARE to creatively tackle.

Recommendation 6: **Increased emphasis should be given to assuring the physical availability of contraceptive methods and avoiding outages in project catchment areas.**

4.2.9 Monitoring and Evaluation

The Population Unit realizes that increased attention needs to be paid to this area. Attention has been given to ensuring that the Project Implementation Report, planned as the basic management tool, has a consistent format and contains service statistics and quality of care data, but the PIRs are not always submitted in a timely fashion.

Service statistics are especially hard to capture. CARE does not provide services directly but works with various partners. Thus, the projects are attempting to collect data from multiple kinds of systems. Of necessity, each field project has developed its own approach. Consequently, the data that flows to the Population Unit cannot be easily aggregated or compared. Currently an attempt is underway to develop a standard management information system (MIS) report form that is workable, given the realities of the field.

As noted, the Population Unit has developed and disseminated an entire series of guidelines to support project managers and technical staff and guide the implementation of CARE's Population Program. There may be a need to reinforce their application at the field level. Several project managers volunteered how helpful the guidelines were; another seemed almost unaware of their existence.

The Population Unit is also looking at low productivity, some of which has been attributed to the short time the projects have been truly functioning and some of which has been attributed to poor project design. The design process that has evolved is more rigorous and the expectation is that new projects will benefit from this increased rigor. The introduction of injectables has lagged expectations in many projects; improvements in productivity are expected once injectables are more widely available. Also the need to develop and expand referral networks is recognized as well as the need to consider new service delivery models. Additionally, attention needs to be given to assuring that the CARE projects are attracting new users and are not simply attracting clients from other services within the community.

The team likewise felt that increased attention needs to be paid to how the linkages between the CBD workers and the clinical sites actually function, especially from the clients' viewpoint. In many countries, in addition to improving community-based services, given CARE's infrastructure and community presence, CARE seems uniquely poised to bridge the gap between the community and clinical family planning facilities. How to most effectively implement this linking function needs closer scrutiny. In the sites visited, there appeared to be considerable demand for long-acting and/

or permanent methods that was not being met. It also appeared that insufficient attention was being given to pregnant women and their impending need for postpartum contraception.

Based on data from the 1988 Uganda DHS Survey, the CREHP project baseline study, and the field visits, it seems reasonable to conclude that the project in Uganda is overwhelmingly reaching couples who have never used a modern contraceptive method before and who may even be learning about contraceptive options for the first time.

In Peru, on the other hand, it did not appear that the populations visited were previously unserved. In the peri-urban areas of Chimbote especially, many of the CBD workers had previously been associated with the Instituto Peruano de Paternidad Responsable (INPPARES), the IPPF affiliate in Peru, and it is possible that many of the CBD clients were previous INPPARES clients. Also a large portion of the client cards reviewed indicated a desire for no more children yet these same clients were generally being given pills a month at a time or condoms 10 at a time.

The range of clinical family planning services available in the Chimbote catchment area was surprisingly broad. The heads of the family planning clinics in the two hospitals in CARE's catchment area both indicated that their hospitals offered immediately post-placental intrauterine devices (IUDs) and tubal ligations for women delivering there. Interval tubal ligations (mini-laparatomies under local anesthesia) were likewise available. A number of health clinics offered interval IUDs. There appeared to be no vasectomy services, although a pilot no-scalpel vasectomy project has been implemented in some areas of Peru.

In both Peru and Uganda, there appeared to be a considerable demand for injectables that has yet to be met. The project design in Peru calls for CBD workers to be trained to administer injectables; a pilot project done with the Population Council showed this to be a successful intervention. However, at present, injectables are available through the MOH clinics only and CBD training for injectables has not yet begun. CBD workers in Bangladesh are also providing injectables on a pilot basis. This would appear to be a promising niche for CARE to explore further.

Injectables were more easily available in Uganda although there had been a major stock-out in the project area at one point which resulted in many fairly new injectable users being switched temporarily to the pill.

Especially as more field projects are implemented and the mix of projects gets even richer, CARE's Population Program will need additional strength and reinforcement in analysis and evaluation. There remains much to be learned about cross-sectoral programming and the multiple meanings of integration. The heavy reliance to date on CBD networks will require continual scrutiny and reappraisal, especially to explore the advantages, limitations, and complexities of sustaining such volunteer programs. Although CARE USA reportedly made a commitment to hire an evaluation officer for the TAG Division 18 months ago, the position has yet to be filled. Consequently, the Population Unit does not currently have in-house access to such expertise on even a part-time basis.

A memorandum of understanding has been signed by CARE USA and the Population Council for joint operations research collaboration in Latin America, a promising sign.

Recommendation 7: **More emphasis needs to be given to increasing the availability of and improving the access to long-acting and permanent modern methods as well as postpartum services.**

Recommendation 8: **Additional strength in evaluation, including operations research, would enhance CARE's ability to implement quality family planning projects and identify and replicate successful approaches.**

4.2.10 Collaboration with Local Institutions

Counterpart relations was ranked high in the midterm evaluations. Both the PFPE-funded and non-PFPE-funded projects partner with a wide range of institutions, nongovernmental as well as governmental. For example, in Uganda, in addition to the governmental MOH, The CREHP Project partners with the IPPF affiliate, FPAU, and the Church of Uganda. CARE has a history of close collaboration with indigenous and grass-roots organizations and has been able to attract high-quality local expertise.

4.2.11 Field Project Staffing

In some countries, there reportedly have been some delays in identifying and hiring project staff. As at the central level, the project staff with whom the team met or spoke appeared very professional, competent, and committed, bringing with them enthusiasm for their work and a rich array of important skills. CARE's ability to attract and retain a highly qualified national staff to implement the PFPE field projects is noteworthy.

4.2.12 Sustainability

Although a number of field projects have a cost recovery component in their design, not much has yet been done with the issue of cost recovery. There is a need to establish clear guidelines regarding cost recovery in the service area and for tracking cost/benefit at the field level. (The Kenya project, which is just starting, intends to begin on a fee-for-service basis, another new model). The Population Unit does monitor costs and considers the present $/CYP cost to be higher than desired; fortunately, the trend is downward. Although cost is a tangible issue at the higher management levels, and although the Population Unit monitors cost to some degree, field staff are not focused on the cost of their operations. Given the importance of this topic to issues of sustainability and replicability and overall funding, considerable attention should be focused on this area in the future.

As noted, many projects rely heavily on networks of CBD agents. The Population Unit has an ongoing task force examining the CBD approach to service delivery. Many questions remain regarding motivation and incentives and the sustainability of these networks. Even at this early stage, the MOH in Peru felt it could sustain the promoters if CARE were to suddenly disappear; in Uganda, the MOH felt it could not.

In general, CARE's close collaboration with its counterparts and the amount and quality of the training provided are important contributions to the sustainability of CARE's work. Because of the emphasis CARE places on working with grass-roots organizations and training beneficiaries to operate the services developed, many projects in other sectors, particularly water/sanitation and agricultural extension projects, have gone on to become self-sustaining. Thus, the precedent exists.

Recommendation 9: **While keeping in mind CARE's commitment to working with the poor and disenfranchised, higher priority should be given to designing and implementing cost recovery components in the field projects. The Population Unit should develop guidance in this area.**

Recommendation 10: **Project managers and field staff need to be made more aware of project costs and the use of cost data as a planning and management tool.**

4.3 Collaboration with other Population CAs

CARE USA has collaborated with and utilized the specialized skills of other population CAs from the very beginning with the Centre for Development and Population Activities (CEDPA) and Management Sciences for Health (MSH) each co-facilitating one of CARE's earliest population activities. Drawing on the existing knowledge and lessons learned in the population field is an explicit component of CARE's learning process approach. Presentations by outside experts, generally from other population CAs, have been key elements in most, if not all, of the population sector's workshops and conferences.

Examples of field collaboration are also numerous, beginning in the Philippines where the PFPE-funded CDLMIS project is essentially a joint undertaking with FPLM. Many projects use training materials developed by other CAs. In Uganda, The CREHP Project has made good use of work previously done by INTRAH. CBD agents there will be selling commodities obtained from The Social Marketing for Change Project (SOMARC). In Peru, collaboration with Pathfinder and the Association for Voluntary Surgical Contraception (AVSC) is being pursued in order to strengthen counseling skills within the MOH and increase the availability of permanent and long-term methods within the MOH facilities to which The MSPP Project refers clients.

Some attempts at field collaboration have not been successful, generally because they were not sufficiently well planned and too much was left to chance. Especially in the area of IEC, several field projects assumed that suitable and sufficient materials would be forthcoming from projects supported by other CAs which never materialized.

As has been seen, a common CARE project design is a network of CBD agents linked generally to public sector clinical facilities. Many other donors and population CAs focus on strengthening clinical services; it would be redundant for CARE to also focus here. Instead what is needed is close, explicit, planned collaboration—joint programming, if possible—to create fully functioning family planning service delivery systems. Although for CARE, such planning and programming is almost totally a field function, many population CAs are more centrally focused; the Population Unit

may need to actively facilitate the development of these types of linkages, especially in countries where the relevant CAs do not have a permanent in-country presence.

Recommendation 11: CARE USA should seek to systematically increase its programmatic field collaboration with other population CAs.

4.4 CARE/USAID Relationship

At all levels, centrally and in the field, the relations between CARE and USAID appeared positive and mutually supportive.

The PFPE Project has had several Cognizant Technical Officer (CTO) changes which at times has made clear communication somewhat problematic. This situation has been ameliorated to a large extent by the assignment of various American Academy for the Advancement of Science (AAAS) Fellows or Michigan Fellows as project liaisons to complement the CTO.

A number of Michigan Fellows have also participated in The PFPE Project via field placements. Both the Togo and Niger field projects have utilized Fellows, and CARE Uganda and CARE Nepal currently have Population and Environment Fellows, both of whom are playing important cross-sector bridging roles. CARE has benefited substantially from both Michigan Fellows Programs; conversely, it appears the Michigan Fellows have benefited substantially from their involvement with CARE. CARE is considered to be a desirable placement that offers a solidly supportive environment and meaningful opportunities to learn and contribute.

4.5 Project Funding

4.5.1 General Funding

Initially, the total cost of The PFPE Project was estimated at US$32.9 million. Of this, US$25.8 million was to be USAID's contribution, originally expected to be composed of US$17.8 million in core funding and US$8 million in buy-in funding. CARE USA was to provide a 40 percent match of USAID's core funding, i.e., up to US$7.1 million to match the expected US$17.8 million in core funding. In FY94 the project authorization was amended to increase the core ceiling from US$17.8 million to US$22.3 million by shifting US$4.5 million from the buy-in ceiling. The buy-in ceiling was thus reduced from US$8 million to US$3.5 million.

The PFPE Project funds have typically been obligated late in the USAID fiscal year, sometimes not until the third quarter. This, fortuitously, has generally coincided with the beginning of the CARE USA fiscal year in July, making funds available as CARE is ready to initiate their year's activities.

Some CARE budgeting regulations have been problematic, i.e., the inability of country offices to rollover central grant funds from year to year. CARE Uganda, for example, had not understood this restriction and had lost a sizable amount the first year of the project. The Population Unit indicated that some field projects had substantial pipelines while others were scraping by on their last few dollars. To deal with this problem, the Unit is more closely monitoring the budgeting on the part of the Country Offices and has also instituted a mid-year reallocation exercise to readjust funding

levels. (It is recognized that this tactic will no longer be applicable under the recent USAID budget structure changes.)

There is some understandable anticipatory concern on CARE's part regarding the recently promulgated field support approach that requires USAID Missions to develop fully loaded yearly projections of the costs that will be incurred by each CA in each country. Once projections are made and approved by USAID/Washington, there reportedly will be no discretion to shift money between countries during the course of the year. There is concern that funding voids will occur as well as that CA "marketing campaigns" will be necessary in order to ensure inclusion in the Missions' field support budget submissions to USAID/Washington.

At the field level, CARE has experienced some unforeseen difficulties in dealing with USAID Missions regarding additional funding for expanding its family planning programming. CARE Peru thought it had received assurances that USAID Mission funds would be forthcoming to fund two additional PFPE Project sites, only to be told at the last minute that funds were not available. USAID/Peru confirmed this had happened but indicated the reason could not be disclosed. CARE is concerned, with reason, about better understanding how USAID manages its budgeting and programming systems.

No indication was found at the field level that transference of funds from CARE headquarters to the Country Offices and then to the field is a problem.

Each Country Office budget has a certain amount of CARE-funded unrestricted funds which usually come from the "lead" member. These funds are used for capacity building, as "seed" money to start new initiatives, for research, to cover matching funds requirements, and to otherwise fill gaps and fund unforeseen needs. In Uganda, for example, this flexibility allowed CARE to hire three field supervisors for The CREHP Project who were not included in The PFPE Project budget.

4.5.2 CARE Match Funds

CARE USA's funding commitment to The PFPE Project was to match USAID's contribution US$0.40 to the dollar. To date, in terms of obligations, CARE has almost matched USAID dollar for dollar by raising US$21 million. To do this, CARE has attracted a diverse range of donors with the major portion of the funds obligated to date from CARE International members who secured funds from private, bilateral, and multilateral sources.

CARE Britain especially has made reproductive health a priority, in part due to the support and technical assistance received from CARE USA's Population Unit. PFPE-funded resources have supported the development of multiple project proposals which CARE Britain has, in turn, submitted to Britain's USAID counterpart, the Overseas Development Administration (ODA). ODA also considers reproductive health a priority and has responded with multiple project grants.

Additional funds have come via CARE USA's Marketing Department. Earlier CARE had conducted some preliminary surveys to gauge the effect on its donor community of adding population and family planning. The net effect was expected to be positive, and, in fact, this has been the case. A direct mail campaign specifically targeted for family planning received an unusually good response and raised almost US$540,000 toward The PFPE Project match.

Lastly, the CARE Country Offices are also expected to provide some matching funds, either by allocating a portion of their CARE-funded unrestricted funds or by obtaining matching funds from in-country donors. CARE Country Offices to date have obligated US$1.9 million of their own funds.

The identification and leveraging of funds specifically for population and family planning activities is considered an important function of the Population Unit in addition to its technical responsibilities. The Unit's expertise in this area has given it a certain degree of flexibility and has strengthened its ability to implement family planning programming in a timely manner. In Peru, for example, when the anticipated funding from USAID/Peru was not available as expected, CARE was able to turn around and secure ODA financing and thus meet its commitment to extend family planning services to two new areas.

Only 28 percent of the match funds (US$1,956,500) have been expended to date. The launching of The PFPE Project, compounded by CARE's move from New York to Atlanta with only one of the original six Population Unit staff remaining, lead to a considerable delay with regard to fund-raising activities. To some extent, a conscious choice was made to initiate programmatic activities first and seek funding second. Also, match funds at the Country Office level were not allocated initially in a timely manner. All these factors have affected the availability of matching funds at an early enough stage to permit expenditures as projected. Consequently, CARE is being given a one-year no cost extension in order to spend down the match funds.

While recognizing how time consuming the raising of match funds has been, the team felt the PFPE matching funds requirement had contributed greatly to the success of CARE's Population Program by increasing CARE's "ownership" of population as a new sector, sharpening CARE's critical thinking when considering how to "market" population to its national and international donor community, and creating a degree of programmatic flexibility that is not possible with a single donor. CARE USA's Marketing Division helps with certain aspects, but the major responsibility rests with the Population Unit. Given that most funds come earmarked for a specific project in a specific country, it does not appear at this time that this function could be easily delegated to some other part of CARE USA. Much remains still to be learned about global fund-raising for population and family planning.

The team felt any follow-on project should have similar matching requirements, in which case the current matching funds pipeline would need to be reprogrammed to incorporate the new match fund requirements.

Funding levels for the two field projects visited appeared adequate, although both CARE Peru and CARE Uganda indicated they could easily utilize increased funding. CARE Peru especially was poised to expand to additional sites; funding was all that was needed. The team could not determine if the funding levels for the other specific PFPE field projects were adequate or not. However, given the interest being expressed by various Country Offices, it does appear that CARE USA could effectively absorb and utilize additional funds if such funds were made available.

4.5.3 Recommendations

Recommendation 12: **CARE USA should also be recognized for its success in raising the PFPE match funds and for its success in attracting a range of donors.**

Recommendation 13: **The issue of Country Office allocation of match funds should be addressed early on in any follow-on project.**

Recommendation 14: **Any follow-on project should also require such a match at approximately the same percentage level but should not be tied to stringent expenditure schedules.**

Recommendation 15: **If a follow-on project is funded and increased funds are available, USAID should consider that CARE USA has additional absorptive capacity for effectively deploying such funds.**

4.6 Actual versus Expected Project Outputs

CARE USA, with few exceptions, is well on the way to meeting or exceeding all the PFPE expected outputs.

- The Population Unit is fully functional; an RTA team is in place.
- More than 20 Country Offices have received technical assistance, and staff from 19 countries have been trained.
- Nineteen Country Offices have included population in their long-range plans.
- Nearly three times the expected match requirement has been obtained (US$21 million raised versus US$7.1 million required).
- To the extent that integration is taken to mean clustering (occupying the same geographic area), the PFPE field projects are clustered with PHC in nine countries, with ANR in seven, with SEAD in five, and with Food Security in four. Other forms of integration are less common but have been implemented.
- Collaborative relations have been established with many more than 10 population and family planning agencies.
- Population policy statements have been developed and institutionalized by both CARE USA and CARE International.
- Evaluation protocols have been designed and institutionalized. Each PFPE field project conducted a baseline survey and completed a participatory midterm evaluation; a final follow-up survey is planned for the end of each project.

- Ten PFPE-funded field projects have been designed and are in various stages of implementation. (The original number of 16 family planning service delivery projects to be designed was reduced to 10 when USAID adopted its Big Country Strategy.)

- Commodities are distributed in all projects.

- Five rather than the expected eight family planning service delivery models are being tested, although what constitutes a distinct service delivery model is unclear.

The major unachieved expected outputs are the CYP targets for the field projects other than Bangladesh. Many projects are just becoming fully operational and their service delivery impact is just beginning to be demonstrated. Also, The PFPE Project still has more than a year left. However, some targets were miscalculated and/or unrealistic. It has been difficult to capture CYPs that are generated as a result of referrals, especially to public sector clinics. At least one project has been unable to access any public sector data. The Population Unit is actively looking at both ways to increase productivity and improve reporting.

Calculating CYPs to measure impact is an imperfect but still instructive indicator. However, just counting the CYPs generated by the PFPE-funded projects ignores the impact of the tremendous leveraging that has occurred with PFPE resources and that has already resulted in functioning family planning projects in seven additional countries.

4.7 Sharing Lessons Learned

To date, CARE USA's efforts to share its lessons learned have been directed primarily and appropriately to the CARE community via both formal and informal mechanisms. Although CARE's Population Program is still being developed and this further development and refinement must still be CARE's main focus, it would not be premature for CARE to begin documenting and sharing its rich experience and lessons learned with the larger community, especially the other major development organizations and the other population CAs. Any organization that is considering or might wish to consider incorporating population and family planning into its activities would certainly benefit greatly from CARE's experiences and lessons learned.

The process by which CARE USA incorporated population and family planning as a major organizational focus could definitely serve as a model for other major development organizations considering such an undertaking. The conceptual framework, policy issues, guidelines and tools developed, and especially the learning process approach should all be instructive and useful. Likewise, the household livelihood security concept and the long-range strategic planning process of the entire CARE organization, which captures CARE's "focus on the client," should be of interest.

Although CARE USA's senior management indicated that several other major development organizations had shown interest in its long-range planning approach, none are known to have specifically approached CARE headquarters or the Country Offices with regard to population and family planning.

Although the focus might be somewhat different, CARE's experiences would also be instructive and should be of interest to other population CAs and to USAID.

The Population Unit is already planning a "dissemination" conference for early 1996, a likely good beginning.

CARE's sharing of lessons learned should also extend to its partners—the counterpart governments, indigenous NGOs/PVOs, and other local organizations with which it works—with particular attention paid to the potential for replicability and sustainability. At present, the sharing of lessons learned is viewed as a function and responsibility of the Population Unit in Atlanta; the field projects should be encouraged to assume this responsibility at the country level.

Recommendation 16: **CARE USA should be encouraged to share its experiences and lessons learned with other development organizations, other population CAs, USAID, and ultimately with its counterparts in the field.**

5. LESSONS LEARNED

The following lessons learned were collected from CARE staff in the field and at headquarters:

- Process is important. The manner in which something is done affects what gets done.
- The careful application of resources can result in considerable multiplication of impact.
- Flexibility and responsiveness are especially valuable traits when implementing new programs.
- Matching fund requirements can have positive programmatic effects.
- Assume nothing; build in critical elements; do not count on "things planned" by others if crucial to your project's functioning.
- Integration is more complex than it sounds.

6. FUTURE DIRECTIONS AND FUTURE NEEDS

Institutionalizing an entire new area of activity, especially a politically sensitive area like population and family planning, was a major undertaking for a decentralized, field-driven development organization like CARE USA. To enable each country to embrace population and family planning on its own terms required time, skill, and effort. Consequently, the major emphasis initially was necessarily on institutionalization and the creation of systems for designing and implementing family planning field projects. At this point, the emphasis is more on the actual implementation of field projects; it is realistic to expect that any follow-on project would continue this evolution of emphasis.

CARE USA's Population Program is already moving in a number of directions congruent with the evolving priorities of G/PHN/POP. There are CARE Country Offices in 13 of the 15 Joint Programming countries (all except Nigeria and Morocco) with family planning projects already implemented in more than half. CARE's number one comparative advantage will, of course, continue to be its infrastructure; CARE has tremendous presence in the communities with which it works. At the community level, when multiple sector projects are clustered together, the community sees CARE, not discrete projects.

As part of the long-range strategic planning process currently underway, each CARE Country Office will systematically consider whether there is a need for population and family planning programming in its portfolio. The expectation is that there will be considerable demand. In addition, CARE wants to expand current family planning programming within countries geographically and by continuing to focus on improving the quality of existing projects.

There is a very strong trend at CARE USA, underscored by the household livelihood security paradigm, toward increased cross-sector programming. In effect, CARE is looking for ways to deliver multiple messages synergistically, for ways to work and act more holistically, more ecologically. For example, as communities increasingly recognize the link between population and the environment, CARE is responding programmatically. In Uganda, a community-based environmental management pilot project is being developed in which the demand for family planning services is expected to play a significant role. The involvement of a Michigan Population and Environment Fellow has greatly enhanced the development of this "bridge" approach between CARE's ANR and population sectors. SEAD sector involvement is also being considered. CARE USA is also developing a girls' education initiative with the expectation that girls' education will in time become a separate sector like population and family planning. In Peru, a CARE-supported women's micro-credit project with a revolving credit fund was starting an educational fund to pay the school fees and educational expenses of the members' daughters. Whereas the population community is giving increased attention to gender equity and women's empowerment issues, it should be noted that gender and equity concerns were in part what led CARE to population and family planning.

CARE USA's reproductive health involvement is another example of the move towards working more holistically. Many CARE field staff and counterparts specifically mentioned reproductive health as a desired priority focus. Of the 15 currently active family planning field projects, 11 also include maternal health services, nine have a sexually transmitted disease component, eight have an AIDS component, three include sex education, two address harmful practices, and one addresses the complications of abortion. The Population Unit team has been developing a

reproductive health strategy; the intent would be to fully operationalize it in a follow-on project. Four field projects have significant components directed specifically at men while three specifically reach out to young adults.

The reproductive health needs of refugee populations are of increasing concern to CARE USA. In this context, CARE and others have been involved in rethinking the role of reproductive health and family planning services in refugee settings. The conventional wisdom has been that such services are not relevant. However, refugees themselves have increasingly indicated a need and desire for such services. CARE USA has an emergency response unit in Atlanta and a center for emergency response in Nairobi with already well-developed emergency relief models covering food, water, shelter, and logistics. CARE was asked by the United Nations High Commission on Refugees to set up six women's health/family planning clinics in Ngara District in Tanzania. The first clinic is now functioning; the other five will open soon. In addition, CARE is part of a consortium that has received private funding to develop models for basic health services with strong family planning components. These models are to be field-tested in a variety of settings. The initial geographic focus is to be on Rwandan refugees in Tanzania, Somali refugees in Kenya, and Sudanese refugees in Uganda.

Although CARE traditionally has had a rural focus, many staff mentioned the need to also be looking at peri-urban interventions, especially in countries where heavy internal migration has resulted in large population shifts and especially in secondary and tertiary peri-urban areas where no other population organizations are working. In Peru, "focusing on the client" led The MSPP Project to extend to the peri-urban area of Iquitos, an area not previously served by any CARE sector. (Peri-urban involvement in Peru is also consistent with USAID/Peru's priorities. To compensate for the neglect of areas away from the capital, due in part to years of terrorism in the countryside, USAID/Peru is reorienting itself toward the public sector and rural areas and secondary and tertiary peri-urban areas.) The non-PFPE funded project in Zambia also serves a predominantly peri-urban population.

Most of the field projects established to date are still basically fledglings; many have just recently reached the point where they could be described as up and running. It is still too early to know which aspects are most successful and which least successful. The various forms and meanings of integration require further definition and exploration. Improving and refining the technical aspects and impact of the existing field projects will require as much attention as expansion; a continued focus on quality will be key.

While there will be even more to share as the field projects mature, CARE already can and should serve as an important resource to other development groups and to other population CAs.

It is CARE's tradition to have an extremely lean headquarters staff. CARE USA's Population Program has only five Atlanta-based staff, three technical and two support. This may not seem like sufficient personpower given the steadily increasing number of field projects, the wide range of technical tasks to be accomplished, and the continuing need to identify potential funding sources. (To a large extent, the fund-raising done by the Population Unit is itself a technical task since it involves the development of field project proposals and their subsequent marketing based on their technical merits.) However, within CARE and compared to other CARE sectors, the Population Unit is considered to have a large technical team relative to the number of projects it backstops.

The continued growth and improvement of CARE USA's Population Program will require additional technical expertise to provide adequate technical support to the field projects. Also, the demands of the field projects must be balanced with the demands of fund-raising. Ideally this expertise would be located both in Atlanta and within the RTA system. The team felt it would not be unreasonable to add one more technical person to the Population Unit in Atlanta; however, this view will likely not be shared by CARE's senior management. As previously noted, additional strength and reinforcement in evaluation, including perhaps some operations research, would enhance CARE's ability to analyze what works best where and why and then move on to the expansion and replication of successful approaches. There remains much to be learned about cross-sectoral programming and the multiple implications of integration.

The Population Unit has already considered the need for expanding the support provided by the RTAs and is moving toward developing a cadre of specialized consultants. As CARE USA's Population Program matures, it is likely that specific projects may well need more targeted, more specialized technical assistance, and this approach should serve CARE well.

Recommendation 17: **Any follow-on project should have a balanced focus between expansion to new countries and quality of care improvements in existing projects.**

Recommendation 18: **Any follow-on project should give special emphasis to reproductive health as a priority focus.**

Recommendation 19: **Any follow-on project should include a mechanism for addressing the reproductive health needs of refugee populations.**

Recommendation 20: **Any follow-on project should specify a clearly defined system for assuring and providing adequate technical support to the field projects.**